Advocate Comments

AARP

National Alliance on Mental Illness (NAMI) Virginia

March of Dimes

Virginia Health Care Foundation

Virginia Poverty Law Center and The Commonwealth Institute

The Hemophilia Association of Virginia and the Virginia Hemophilia Foundation

Virginia Chapters of the National Multiple Sclerosis Society

National Patient Advocate Foundation

Written Comments on Third Background Memorandum on Health Benefit Exchange Issues:

Preparing for Potential 2012 Health Benefit Exchange Legislation

Submitted by Bill Kallio, State Director, ARP Virginia

On behalf of the 1,000,000 members of AARP in the Commonwealth of Virginia, we appreciate the opportunity to respond to the August 12th Third Background Memorandum on Health Benefit Exchange (HBE) issues, seeking feedback on preparing for potential 2012 Health Benefit Exchange legislation. We reiterate our very strong interest in working with you as you develop an insurance marketplace that will better serve the needs of the individual and small business markets. We believe that the HBE has the ability to ensure access, promote quality, and provide affordable coverage to the citizens of the Commonwealth

As the Health Care Reform Initiative Advisory Council and Task Force make final decisions regarding these issues and the upcoming 2012 legislative agenda, what is in the best interests of consumers should be its guiding force. AARP, in its previous comments has addressed many of the issues identified in the present memo and we would wish to refer you to our earlier statements. The present comments respond to Sections V and VI of the memorandum.

Section V: Decisions that could be made by the Legislature, the Governance Structure, and the Director of the Health Benefit Exchange

AARP believes that to move forward on a state health benefit exchange, the Commonwealth should, to the greatest extent possible, delegate the majority of identified responsibilities to the Governing Board. This entity will have the identified mission and expertise necessary to accomplish these responsibilities within the requisite and very challenging timelines. In addition, we believe the Governing Board should also be tasked with the responsibility of ensuring close coordination with all relevant state agencies, as well as with being the central point of interface with appropriate Federal agencies.

While it is our preference that the majority of HBE functions be delegated to the Board, with respect to 3(f) in particular, we believe a legislative role would be appropriate, as this function involves the identification of potential exemptions from state law.

While it is appropriate for the Executive Director to have the authority to administer and manage the day-to-day operations of the HBE, we believe that when major or consequential policy decisions arise, the Executive Director should be required to inform, consult and, when appropriate, seek

approval from the Board. These policy decisions would likely include decisions about entering into interagency agreements or MOU's with other agencies, and certain decisions about delegating critical Exchange functions to independent contractors. In addition, the Executive Director should be required to involve the Board when contracts of a certain monetary value are being let. This is so, because Board has ultimate responsibility for the effective functioning of the HBE and fulfillment of its responsibilities.

VI. The Basic Health Plan

With respect to the Basic Health Plan (BHP), AARP believes this complicated issue requires a thorough analysis before determining whether the BHP approach will be in the best interest of Virginia's consumers and the HBE. The arguments for and against the Commonwealth creating and operating a BHP are well laid out in the memo, and each of these will need to be examined thoroughly. Additional information beyond what has been disseminated in the current memo will also be needed to make this determination. In particular, we will need to understand how the operation of a BHP would impact the size of the HBE. We would also need to understand how having a BHP would affect people between 100 and 200 percent of poverty as well as continuity of care. The potential BHP population in Virginia, 600,000, could be used to expand the Medicaid pool significantly, but doing this would also reduce the potential HBE pool from the current one million uninsured to about 400,000. Since the decision on this issue will impact Medicaid and the HBE's ability to be an active purchaser, obtain competitive rates and effect quality improvements, etc., careful analysis is appropriate.

Fortunately, the BHP timeline is one that provides the Commonwealth with room for this more comprehensive study. Therefore, we would suggest that there is no immediate need for a final determination at this point in time.

AARP appreciates the opportunity to offer our input on these issues as we work together to develop a Health Benefit Exchange that reflects the values and meets the needs of the Commonwealth and all Virginians. If you have any questions, or desire additional information with respect to these comments, please contact Bill Kallio, State Director, AARP Virginia, 707 E. Main St. Suite 910, Richmond, VA 23219. Tel: 804-344-3041 email: bkallio@aarp.org.

To: Virginia Health Reform Initiative Advisory Council and Task Force Members

From: The National Alliance on Mental Illness (NAMI) Virginia

RE: VHRI Third Memorandum on Health Benefit Exchange Issues—Topic: Preparing for Potential 2012 Health Benefit Exchange legislation

Date: August 26, 2011

Thank you for the opportunity to provide comments on the authorizing legislation required to implement the health benefit exchange in Virginia. We offer the following comments:

Section V – Distribution of Decision-making for the Exchange

Specifics regarding #1, 2 and 3b must be included in the legislation. In addition #3e, #3f, and parts of 3i should be dealt with in the 2012 legislation. Please find additional comments:

- **#2 a, b and c. Governance –** We agree with the Advisory Committee's preference that the Exchange be created as a 'quasi-governmental' entity and the preliminary decisions to have a diverse Governance Board and/or advisory committee comprised of 11-15 members appointed to staggered terms. Regarding the 2012 legislation we believe it should create both a Governing Board and an Advisory Committee. As stated in earlier comments that we submitted, we also believe it should include specific types of experience and expertise required for members of the Governing Board who would be appointed by the Governor and General Assembly. For example two consumer representatives with expertise in public health insurance programs and the needs of low income, disabled, and uninsured populations; one small business representative; one member with expertise in health care financing and economics; one member with expertise as an insurance actuary; and two at-large members with expertise in an any of the above-described areas. The Advisory Committee could have broader representation and would be selected by the Board and Executive Director Advisory committee should be established to include the expert advice and perspectives of critical stakeholders essential to the design and implementation of the Exchange, and to focus on specialty areas that need further study or guidance.

- **#2 c. Conflict of Interest. – L**egislation should contain strong conflict-of-interest rules to prevent those with direct financial interests from making decisions regarding the Exchange. Members of the Governance Board will have a fiduciary duty to make decisions that are in the best interest of the overall exchange. This includes seeking to provide the most affordable and quality health plans possible for Virginia consumers and small businesses. As we stated in our earlier comments Virginia's legislation concerning governance should specify that no employees or affiliates of insurers or insurance brokers can serve as voting members of the governing board for the Virginia Exchange, to prevent conflicts-of-interest and even the appearance of a conflict.

- **#3bi. Exchange Executive Director should choose staff.** The VHRI memorandum states the legislation would establish the Board's authority to choose the "Executive Director and staff". While the Board should choose the Director, staff decisions should be left to the Executive Director, who will lead the day-to-day operations of the Exchange.

- **#3bii. Discretion regarding plan participation.** The 2012 legislation should give the Board discretion to strengthen requirements for plan participation. The Board must have the authority to evaluate the quality of health plans in the Exchange, in terms of quality of care provided, networks and costs. The Board must have the ability to ensure the best value for Virginia consumers and purchasers. This must include the ability to negotiate prices to ensure the affordability of plans offered.

- **#3biii. Active Recruiting.** Virginia's Exchange board should be active in recruiting and selecting plans for participation. In other words, the exchange should not be required to accept all plans if they do not meet reasonable standards of quality and value. The legislation should give the Board clear authority and discretion to set standards above the minimum and to deny plans that do not meet the needs of consumers.

- **#3e. Funding Mechanism –** This should be determined in the legislation in order to meet the June 29, 2012 deadline for a Level Two Establishment grant.

- **#3f. Congruence with other state laws.** The 2012 Legislation should include specific provisions that require the Exchange and its Governing Board to adhere to open meeting, freedom of information (FOIA) and rulemaking laws.

- **#3h. Setting broad goals and accountability mechanisms' can be left to Governance Board.** The Governance Board will be able to assess the realistic benchmarks for the Exchange and implement procedures to monitor the Exchange's effectiveness in increasing coverage and providing affordable insurance options for the Virginia consumer.

- **#3i (ii & iii). Competition policies, transparency of information and comprehensive reporting requirements must be addressed by the General Assembly and the Governance Board.** The issues of competition and transparency both inside and outside of the Exchange are very important for the Virginia consumer. Health plans must be affordable and comprehensive, and Virginians need to have complete and easily understood information to make informed choices on coverage. The 2012 Legislation should require transparency and comprehensive reporting by health plans both in and outside the Exchange.

    - **Adverse Selection:** The legislation also must include rules to ensure competition and prevent adverse selection. NAMI Virginia provided extensive comments about ways to minimize adverse selection in response to VHRI's Memorandum #2. Our complete comments can be found here: http://namivirginia.org/assets/pdfs/NAMI%20VA%20VHRI%20Memo%202%20Comments.pdf but as a basic concept the legislation must require companies to

offer the same plans inside and outside of the exchange and prohibit insurers outside the exchange from only offering less comprehensive and less expensive coverage that attracts a younger and healthier risk pool.

- **#3(i)(i). Brokers.** If the Legislation addresses the role of brokers, no certification requirements should be included that would prevent direct service providers, community based organizations and others working with low-income populations from operating as Navigators. In fact, if addressed in the legislation, statutory language should specifically authorize those entities to serve as navigators.

- **#4. The General Assembly should delineate Exchange duties, but Governance Board should implement—**The VHRI white paper correctly lists the minimum Exchange requirements under the Affordable Care Act. Thus, the General Assembly must include these duties in the authorizing legislation. However, the Governance Board and Exchange staff should be responsible for details and implementation.

VI. The Basic Health Plan

Virginia should fully evaluate a Basic Health Plan for individuals with income below 200 percent of the Federal Poverty Level. The Basic Health Plan is an alternative to health coverage through the Exchange. If a state adopts a Basic Health Plan, eligible individuals must get their health coverage from the Basic Health Plan instead of the Exchange. A Basic Health Plan could provide many significant advantages for low income people in Virginia, and it could also be in the state's interest to have such a program because more individuals will secure coverage with a Basic Health Plan in place. More research and analysis is needed to fully evaluate the cost and benefits of a Basic Health Plan and to determine if the federal payment for a Basic Health Plan will fully support such a program. Therefore we encourage the VHRI to recommend a complete analysis of this option.

August 25, 2011

Statement of the March of Dimes,

Virginia Chapter and Maryland-National Capital Area Chapter

Response to VHRI Memorandum: Preparing for Potential 2012 Health Benefit Exchange Legislation

Thank you for the opportunity to respond to the August 12, 2011 Virginia Health Reform Initiative "Third Background Memorandum on Health Benefit Exchange Issues –Topic: Preparing for Potential 2012 Health Benefit Exchange Legislation." The two March of Dimes Virginia Chapters greatly appreciate the magnitude of the important and difficult work being undertaken by the VHRI Advisory Council and Task Force members.

The mission of the March of Dimes is to improve the health of women of childbearing age, infants, and children by preventing birth defects, premature birth and infant mortality. We would like to offer the following comments for your consideration with regard to whether the state should establish a Basic Health Plan. If the state chooses to institute a Basic Health Program, it should include a comprehensive package of maternal and child health coverage, including:

- The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for children (which they would receive under Medicaid and should not lose under a Basic Health Program);
- The preventive health benefits for women recommended by the Institute of Medicine, which include preconception and full prenatal care for all women of childbearing age; and
- Full maternity care (prenatal through postpartum).

Women of childbearing age, infants and children have unique health care needs and the inclusion of these components will help improve the health outcomes of babies born in the Commonwealth and will ensure that the Basic Health Program is designed to maximum the health benefits for these populations. If the state chooses <u>not</u> to institute a Basic Health Program, it is particularly critical that high risk pregnant women and infants and children with special health care needs continue to have access to services and providers they require with no disruption.

In addition, we urge that the Health Benefit Exchange provide a streamlined determination process for individuals eligible for Medicaid, FAMIS, FAMIS Moms and other health programs, and seamless access to these programs. This is important because, for a variety of reasons, including fluctuating income and eligibility, pregnant women, infants and children could qualify for various programs from one year to the next. Also, for some

families, parents may be eligible for coverage through the exchange, but their children may be eligible for Medicaid or FAMIS due to differing eligibility levels for different populations.

Thank you again for this opportunity to present our thoughts about a possible Basic Health Program and the need for a streamlined eligibility determination process within the health benefit exchange.

VIRGINIA
HEALTH CARE
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August 26, 2011

The Honorable William A. Hazel, Jr., M.D.
Secretary of Health & Human Resource
Len M. Nichols, PhD, Director
Director of George Mason University
Center for Health Policy Research & Ethics
Patrick Henry Building
1111 East Broad Street
Richmond, VA 23219

Re: Third Background Memo on Health Benefit Exchanges

Dear Secretary Hazel, Dr. Nichols and Members of the Virginia Health Reform Advisory Council:

Thank you for the opportunity to comment on the third memorandum related to the creation of a Health Benefits Exchange in Virginia. These comments on behalf of the Virginia Health Care Foundation (*VHCF*) directly relate to our work and experience with the health safety net population (*those with incomes ≤ 200% FPL*) over the past nineteen years.

In particular, VHCF has enrolled 57,000 children and pregnant women in Virginia's FAMIS and FAMIS Plus (Medicaid) programs since 1999 via its *Project Connect* initiative. During that time, VHCF has also trained nearly 8,300 health and human services professionals (*including eligibility workers at local departments of social services*) about the rules and regulations of the FAMIS programs through its SignUpNow (*SUN*) program. The training, which is available online or in person, utilizes an extensive SUN toolkit that VHCF updates annually in conjunction with the Virginia Department of Medical Assistance Services and the Virginia Department of Social Services.

Rules for Navigators

Through our work, we have developed and are continually refining techniques that are most effective in identifying and reaching out to low income Virginians. This is typically a very different population than that which will likely comprise much of the individual or small group market that will be eligible to purchase insurance through the Exchange.

We strongly encourage any Council recommendations or legislation regarding Navigators to specifically allow staff of nonprofits and community-based organizations to be Navigators. We also suggest that any standards or certification requirements required for Navigators, who help the Medicaid and health safety net population, be reasonable and focus on understanding the rules of Medicaid eligibility rather than private insurance.

Perhaps there could be a separate tier of Navigators who focus solely on the health safety net population?

Basic Health Plan

We encourage thorough analysis and serious consideration of the Basic Health Plan to determine the ultimate cost/benefit to the state, and to Virginians with incomes from 134-200% FPL. If a Basic Health Plan can be made to work financially, it would be very helpful in alleviating the churning issue that we have all been so concerned will occur when the Medicaid expansion for adults kicks in in 2014.

Our experience in the health safety net has helped us understand that Virginians living in the income range of 100-200% FPL typically have hourly jobs, with their compensation varying from week to week. We see this with their children, who swing back and forth regularly from eligibility for Medicaid (*up to 133% FPL*) to eligibility for FAMIS (*134-200% FPL*). Virginia would benefit greatly if there were a Basic Health Plan that would be available for adults with incomes from 134-200% FPL, just as FAMIS is available for Virginia's children.

Although Virginians with incomes from 134-200% FPL may be eligible for a subsidy if they purchase insurance through the Exchange, the truth is that most will be unable to afford it. A person living at that income level is struggling to survive each day, and has no "extra" income to purchase insurance. A Basic Health Plan designed for these Virginians would be the most effective way to ensure that they have health insurance.

Thank you for your consideration.

Sincerely,

Deborah D. Oswalt
Executive Director

Comments on Exchange White Paper #3: Preparing for 2012 Exchange Legislation

To: Virginia Health Reform Initiative

From: John McInerney, Health Policy Director, The Commonwealth Institute for Fiscal Analysis; Jill Hanken, Staff Attorney, Virginia Poverty Law Center

The Commonwealth Institute

VIRGINIA POVERTY LAW CENTER

The implementation of a health benefit exchange in Virginia will require authorizing legislation that sets out the governance structure for the exchange and many of the rules that the Exchange will need to follow.

We have the following comments:

1. Section IV – Role of the Bureau of Insurance (BOI)

As noted in the paper, both the BOI and the Department of Health currently carry out certain reviews/certifications for health insurers in Virginia. As part of Virginia's implementation of the ACA, these various functions should be consolidated within one agency. It no longer makes sense for the Department of Health to have oversight of one kind of insurance plan (i.e. HMOs), but not others. Most of the ACA dictates apply to all types of health plans and this new reality should be reflected in Virginia law. We have previously indicated our support for the BOI to perform all ACA requirements for certifying qualified health plans.

While not included in the chart, it is important to point out that the BOI will also play a role in determining whether Virginia health plans meet the ACA Medical Loss Ratio requirements. We suggest that review of MLR be included in later versions of the certification chart.

2. Section V – Distribution of Decisionmaking for the Exchange

"Major Decisions that Must Be Addressed By the General Assembly" – We agree that specifics regarding #1, 2 and 3b must be included in the legislation. In addition, we believe that #3e (funding), #3f (adherence to other state laws) and parts of #3i (competition, transparency and reporting) should be dealt with in the 2012 legislation. The remaining items can be delegated to the Governing Board.

It is absolutely essential for the legislation to give the Exchange Governing Board the discretion and authority to set strong requirements for plan participation, including quality of care, network adequacy and costs. Equally important are legislative standards to ensure competition and prevent adverse selection by requiring companies to offer the same plans inside and outside of the Exchange and prohibiting insurers outside the Exchange from only offering less comprehensive/less expensive coverage that attracts a younger and healthier risk pool. Without such provisions, the viability of the Exchange could be jeopardized.

Specific comments follow :

- **#2 a, b and c. Governance**—As stated in the VHRI white paper, under the Affordable Care Act the General Assembly must set up the governance structure for the Exchange. We strongly agree with the Advisory Committee's preference that the Exchange be created as a "quasi-governmental" entity and the preliminary decisions to have a diverse Governance Board and/or advisory committee comprised of 11-15 members appointed to staggered terms.

  As to specifics for the legislation: First, we believe the legislation should create both a Governing Board and an Advisory Committee; Second, we believe the legislation should include the specific types of experience and expertise required for members of the Governing Board who would be appointed by the Governor and General Assembly. In earlier comments we identified the range of expertise needed: certain ex-officio members representing state agencies; two consumer representatives with expertise in public health insurance programs and the needs of low income, disabled, and uninsured populations; one small business

representative; one member with expertise in health care financing and economics; one member with expertise as an insurance actuary; and two at-large members with expertise in any of the above-described areas. The Advisory Committee could have broader representation and would be selected by the Board and Executive Director.

- **#2 c. Conflict of Interest**—We wish to stress that the legislation should contain strong conflict-of-interest rules to prevent those with direct financial interests from making decisions regarding the Exchange. Members of the Governance Board will have a fiduciary duty to make decisions that are in the best interest of the overall exchange. This includes seeking to provide the most affordable and quality health plans possible for Virginia consumers and small businesses. As we stated in our earlier comments, to prevent conflicts, and even the appearance of a conflict, Virginia's legislation concerning governance should specify that no employees or affiliates of insurers or insurance brokers can serve as voting members of the governing board for the Virginia Exchange.

- **#3bi. Exchange Executive Director should choose staff**—The white paper states the legislation would establish the Board's authority to choose the "Executive Director and staff." While the Board should undoubtedly choose the Director, staff decisions should be left to the Executive Director, who will lead the day-to-day operations of the Exchange.

- **#3bii. Discretion regarding plan participation**—The 2012 legislation should definitely give the Board discretion to strengthen requirements for plan participation. The Board must have the authority to evaluate the quality of health plans in the Exchange, in terms of quality of care provided, networks and costs. The Board must have the ability to ensure the best value for Virginia consumers and purchasers. This must include the ability to negotiate prices to ensure the affordability of plans offered.

- **#3biii. Active Recruiting**—As we said in previous comments, Virginia's Exchange board should be active in recruiting and selecting plans for participation. In other words, the exchange should not be required to accept all plans if they do not meet reasonable standards of quality and value. The legislation should give the Board clear authority and discretion to set standards above the minimum and to deny plans that do not meet the needs of consumers.

- **#3e. Funding Mechanism**—This should be determined in the legislation in order to meet the June 29, 2012 deadline for a Level Two Establishment grant.

- **3f. Congruence with other state laws**—The 2012 Legislation should include specific provisions that require the Exchange and its Governing Board to adhere to open meeting, freedom of information (FOIA) and rulemaking laws.

- **#3h. Setting broad goals and accountability mechanisms can be left to Governance Board**—The Governance Board will be able to assess the realistic benchmarks for the Exchange and implement procedures to monitor the Exchange's effectiveness in increasing coverage and providing affordable insurance options for the Virginia consumer.

- **#3i (ii & iii). Competition policies, transparency of information and comprehensive reporting requirements must be addressed by the General Assembly AND the Governance Board**—The issues of competition and transparency both inside and outside of the Exchange are very important for the Virginia consumer. Health plans must be affordable and comprehensive, and Virginians need to have complete and easily understood information to make informed choices on coverage. The 2012 Legislation should require transparency and comprehensive reporting by health plans both in and outside the Exchange.

  The legislation also must include rules to ensure competition and prevent adverse selection. We made lengthy comments in response to White Paper #2 about ways to minimize adverse selection which could destabilize the exchange and hurt its viability. As a basic concept, the 2012 Legislation must require companies to offer the same plans inside and outside of the exchange and prohibit insurers outside the exchange from only offering less comprehensive/less expensive coverage that attracts a younger and healthier risk pool.

- **#3(i)(i). Brokers**—If the Legislation addresses the role of brokers, no certification requirements should be included that would prevent direct service providers, community based organizations and others working with low-income populations from operating as Navigators. In fact, if addressed in the legislation, statutory language should specifically authorize those entities to serve as Navigators.

- **#4. The General Assembly should delineate Exchange duties, but Governance Board should implement**—The VHRI white paper correctly lists the minimum Exchange requirements under the Affordable Care Act. Thus, the General Assembly must include these duties in the authorizing legislation. However, the Governance Board and Exchange staff should be responsible for details and implementation.

  We are comfortable with the outlines of "Major Policy Decisions That Could Be Delegated Entirely to the Board" and the "Major Policy Decisions That Could Be Delegated to the Executive Director."

3. Section VI – The Basic Health Plan

Virginia should fully evaluate a Basic Health Plan for individuals with income below 200 percent of the Federal Poverty Level (FPL).

As described in the VHRI white paper, the ACA grants states an option to create a Basic Health Plan (BHP) for adults with income above the new Medicaid eligibility level [133% of the federal poverty level (FPL)] but less than 200% FPL. Using 2011 figures (without consideration of applicable disregards), this population would have the following income:

Family Size	133% FPL Annual Income	200% FPL Annual Income
1	$14,484	$21,780
2	$19,565	$29,420
3	$24,645	$37,060
4	$29,726	$44,700

The Basic Health Plan will also cover legally residing immigrants with incomes below 200% FPL who are not eligible for Medicaid.

The Basic Health Plan is an alternative to health coverage through the Exchange. If a state adopts a BHP, eligible individuals must get their health coverage from the BHP instead of the Exchange.

We believe a BHP could provide many significant advantages for low income consumers in Virginia, and it could also be in the state's interest to have such a program because more individuals will secure coverage with a BHP in place. More research and analysis need to be completed to fully evaluate the cost and benefits of a BHP and to determine if the federal payment for a BHP will fully support such a program. We encourage the VHRI to recommend a complete analysis of this option.

Advantages

a) Affordability
The BHP option allows states to create a program with lower out-of- pocket costs than Exchange plans. This would be an obvious benefit for low-income consumers, especially if Congress reduces the federal cost-sharing subsidies.

b) More Uninsured Virginians will Obtain Health Insurance
Without a BHP, people with income above Medicaid levels will have to seek coverage from the Exchange, and those plans may still prove too costly. If low income people are unable to afford Exchange plans (and they meet exceptions to the mandate) they may simply remain uninsured – continuing to forego needed health care and/ or shift costs to the rest of the market through charity care and other mechanisms. The BHP would be more affordable – enabling more low income individuals and families to actually get insurance.

c) Family Unity
A BHP can facilitate coverage of adults and their children under one umbrella rather than splitting families between the Exchange and other state-administered programs. For example, Virginia's FAMIS program covers children with family income up to 200% FPL. With a BHP, the parents of FAMIS eligible children ideally could receive coverage from the same health plan. Aligning coverage and renewal dates for the entire family supports the concept of a "medical home."

d) Continuity of Care
People and families with income below 200% FPL are likely to experience more fluctuations in income that would technically move them in and out of Medicaid eligibility. A BHP would provide much easier transitions between programs, especially if the same health plans were available. Avoiding gaps in coverage enhances continuity of care and, again, promotes the "medical home" concept.

The more a state's Basic Health program resembles its Medicaid and/or CHIP programs in terms of having the same provider network, covered benefits, and cost-sharing requirements, the easier it will be for families whose incomes fluctuate during the year. We envision the BHP being administered by DMAS as an extension of Medicaid and FAMIS – programs DMAS already operates.

e) Coverage for Immigrants
The BHP provides federal financing to cover lawfully present immigrants who are not currently covered under Medicaid or FAMIS. Virginia currently has many gaps in Medicaid/ FAMIS coverage for legal immigrants. While the state could exercise existing options to cover several groups of legal immigrants (e.g. pregnant women during their first five years in the US, FAMIS-eligible children during their first five years in the US, and all legal immigrants following the five-year bar) Virginia has not adopted these options. The BHP would offer coverage to these

groups and other legal immigrants – some of whom would have very low income and not be able to afford Exchange products.

Concerns and Analysis Needed

a) Will the federal dollars that are available to support the Basic Health program be adequate to create such a program?

To fund a BHP, the federal government will transfer to the state 95% of the premium credits and cost sharing reductions that individuals would otherwise have received if enrolled in the Exchange. In theory, States will receive substantially more per capita than they currently spend on Medicaid, making it possible for them to operate a BHP with lower out-of-pocket costs and possibly better benefits for enrollees and higher payments to providers (than current Medicaid payments). Such analysis would require an estimate of the number of people who would be in the Basic Health pool, the expected per capita costs, and a projection of the available federal revenue.

b) Will funding be sufficient to offer lower premiums and cost sharing than in Exchange plans?

Since the greatest advantage of a BHP for low income consumers is the potential for lower out of pocket costs, this aspect of the financial analysis is critical. Estimated "savings" can be used to reduce cost-sharing and increase benefits for Basic Health enrollees to, for example, align benefits with those provided in Medicaid/FAMIS. Competitive purchasing would be integral to achieving this goal.

c) How will the state ensure adequate provider networks and participation?

Provider payment rates in a BHP will be likely be lower than those paid in commercial plans offered by the Exchange, but they could be higher than Medicaid/FAMIS. Virginia could consider incentives to encourage plan and provider participation by combining the purchase of Medicaid/FAMIS and BHP plans and coordinating provider payments.

The impact of payment rates on the adequacy of provider networks and provider participation must be thoroughly examined. If a BHP is adopted, it must incorporate strong safeguards regarding network adequacy in its contracts, and the ability and commitment to enforce the contract if problems arise.

d) Are Virginia Health Plans and providers interested in providing coverage through the BHP?

The law contains many requirements for services, quality, case management, care coordination and a Medicaid Loss Ratio of 85%. We would expect that plans and primary care physicians currently serving Medicaid and FAMIS enrollees would also have an interest in BHP. To the extent possible, the state would want to contract with health plans and providers that provide coverage in Medicaid, FAMIS and Basic Health to ensure that the provider network across all three programs includes an array of providers that meets the needs of this population. That way, families would not have to switch plans and providers when they move between programs.

e) Will a BHP jeopardize the viability of the Exchange?

There must be additional analysis to consider the impact that a BHP would have on insurance market dynamics. If the Basic Health pool is removed from the Exchange, the Exchange risk pool for individuals becomes smaller. Will that affect the viability of the Exchange and/or the willingness of plans to participate in the Exchange?

In summary, the Basic Health Plan deserves serious consideration. It is a very attractive option because it can offer more affordable coverage and better continuity of care for low-income Virginians with income below 200% FPL. However, additional work is needed to fully evaluate the merits of a BHP – for both Virginia and the target population. VHRI should recommend comprehensive analysis of the option.

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August 25, 2011

VHRI@governor.virginia.gov

RE: Comments on September 9 Memorandum on Preparing for Potential 2012 Health Benefit Exchange legislation

On behalf of the Virginia Hemophilia Foundation and the Hemophilia Association of the Capital Area, we are pleased to provide these comments to the Advisory Council of the Virginia Health Reform Initiative for the September meeting on the Health Benefits Exchange.

Hemophilia and other bleeding disorders are largely inherited disorders in which one of the proteins needed to form blood clots is missing or reduced which can lead to excessive bleeding. The bleeding can occur spontaneously or as a result of trauma. Fortunately, hemophilia is a low prevalence disorder affecting approximately 300 Virginians—but, unfortunately, hemophilia is extremely expensive to treat. Care of an uncomplicated patient with hemophilia costs approximately $150,000 per year. However, that figure is much higher for many people with severe bleeding disorders. People with hemophilia who lack health insurance must currently rely on public health care services, premium support, and/or assistance from pharmaceutical companies. These are stopgap measures and not designed for the lifetime requirements necessary for the care of people with hemophilia and other bleeding disorders.

Our concerns about the costs and availability of treatment for hemophilia and other bleeding disorders guide our comments for the VHRI to consider at the September meeting. We therefore ask that the VHRI recommend legislation to the General Assembly that accomplishes the following.

1. Creation of the HBE as a quasi-governmental agency to permit flexibility in procurement and other policies but one that maintains provisions for freedom of information.

2. Establishment of a Board of Directors and an Advisory Committee. The Board should be responsible for policy development and program evaluation. The Advisory Committee should be responsible for informing the Board on HBE implementation, operation, and policy issues. We strongly believe that the

Advisory Committee should have broad consumer representation and minimally include a representative from the community of individuals with lifelong, chronic, and potentially life-threatening conditions whose treatment may be costly but critical.

3. We strongly recommend that enabling legislation also provide for the following:

    a. Strong conflict-of-interest policies for the members of the Board of Directors;

    b. Transparency and the use of "plain English" in the development of insurance plans in the HBE; and

    c. Insurance plans that impede adverse selection.

Thank you so much for your request for public comments. We appreciate this opportunity.

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National
Multiple Sclerosis
Society

To: Virginia Health Reform Initiative (VHRI)

From: Ashley Chapman, Virginia Chapters of the National Multiple Sclerosis Society

Date: August 25, 2011

Re: Comments on the development of a Virginia Health Benefit Exchange

Introduction

The National MS Society supports the implementation of the Patient Protection and Affordable Care Act (ACA) because we believe it will make great strides toward achieving needed improvements in health coverage and care for people with multiple sclerosis (MS).

Health Benefit Exchanges (HBE) are designed to bring high-quality, easy-to-understand health coverage options to consumers, especially the individuals and small businesses that will turn to them for help choosing, and in many instances paying for, health coverage starting in 2014. We believe that Exchanges should function as marketplaces for high-value coverage that is transparent and accountable, responsive to consumers' needs, user-friendly and stable.

To achieve these goals, we urge the VHRI to adopt the following principles and recommendations:

The Exchange should be subject to our state's open meeting laws and allow for public input for decision-making bodies, along with other measures that seek to ensure the accountability and integrity of the Exchange.

The Exchange must be subject to the Administrative Process Act, Va. Code § 2.2-4000 *et.seq*. regarding regulatory issues and rulemaking, to insure full disclosure of program operations and eligibility rules and to promote public input.

The Exchange must be subject to the open meeting and open record provisions of the Freedom of Information Act, Va. Code § 2.2-3700, *et.seq*. to guarantee public access to information and meaningful public input.

The Governing Board should be diverse, expert and include consumer representation.

We strongly emphasize the necessity of consumer representation on the Governing Board. The Exchange is intended to ensure that consumers have meaningful access to high quality,

affordable health insurance. This goal cannot be achieved without proportionate consumer representation and meaningful involvement in its governing body.

Consumers should not be outnumbered by providers and/or insurers on the Governing Board.

The Exchange legislation should require board appointments to take into consideration the racial, ethnic and geographic diversity of the state and include members who can represent the special needs of people with disabilities, people with chronic illnesses, low-income and uninsured consumers who will depend on the Exchange for access to health coverage.

The Governing Board must avoid all conflicts of interest.

The Exchange must be subject to broad conflict of interest provisions, including the State and Local Government Conflict of Interests Act, Va. Code §2.2-3100 *et.seq.*

Virginia should take an active role in making sure that only health plans that provide good value to consumers are permitted to sell coverage through the Exchange.

The Exchange can play a significant role in establishing a basic infrastructure that helps contain costs and stabilizes coverage. Virginia should choose to serve as an "active purchaser" and design bidding requirements and selection practices for insurers interested in selling policies through the Exchange. When active purchasing arrangements fit with local market conditions, the interests of policyholders and taxpayers are served through cost-lowering price negotiations. Value can be demonstrated with accountability measures such as analyses of how provider networks are keeping with enrollees' needs and other objective measures of performance and quality.

Exchanges should promote value in coverage and stability in the insurance marketplace.

It is in the public's best interest to minimize the likelihood of adverse risk from the outset of the Exchange. They key to minimizing adverse selection is to create a "level playing field" for all insurers, including enacting similar rules for insurers operating outside and inside the Exchange. The goal should be robust competition between plans based on their quality and price, not variation in products that result in the poor distribution of risks.

The state should ensure that coverage for all needed services currently required under state benefit mandates is provided in Exchange plans.

Our hard-won state laws require that insurers in Virginia cover specific benefits for enrollees. These mandates have been important to consumers with many health care needs. People living with multiple sclerosis and other chronic illnesses, require a spectrum of preventive, medical, rehabilitative, mental health and long-term care services to manage their disease and symptoms.

All services of the exchange should be accessible to all persons eligible for its products, regardless of any disabling condition or limited English proficiency.

The Exchange must assure that products and services are equally accessible to customers. This will require dedicated efforts to overcome barriers due to physical and cognitive disabilities, limited English proficiency and low health literacy.

Exchange outreach, services and products should be responsive to consumers' needs and user-friendly.

Outreach should be targeted to consumers who are eligible for tax credits and cost-sharing reductions. Enrollment help from qualified navigators should be provided and widely accessible throughout all communities where eligible individuals live and work. To simplify the application and enrollment process, states should design systems that use known sources of income and other data to determine eligibility rather than requiring applicants to submit new documentation.

Due to the large rural population of the state, it is important that outreach and Exchange information be available both on and off the web for those who do not have internet access.

The Exchange should be designed to meet the particular needs of individuals who, due to fluctuations in income, "transition" between public coverage programs like Medicaid and private coverage through the Exchange. Assuring continued enrollment in health coverage is the best way to achieve the continuity of care that people with MS and other chronic conditions require.

Basic Health Option

Virginia should fully evaluate a BHP plan for individuals with incomes below 200 percent of the Federal Poverty Level. A BHP could provide many significant advantages for low income consumers in Virginia and deserves a complete cost-benefit analysis to determine if it is the right choice for the Commonwealth.

For more information, please contact:

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NPAF National Patient Advocate Foundation
The Patient's Voice | since 1996

August 23, 2011

Ms. Cindi B. Jones
Director of the Virginia Health Reform Initiative
Dr. Len Nichols
Director of the George Mason University
Center for Health Policy Research and Ethics
Patrick Henry Building
1111 East Broad Street
Richmond, VA 23219

RE: Comments on the August 12 Memorandum on Preparing for Potential 2012 Health Benefits Exchange Legislation

Dear Ms. Jones, Dr. Nichols and members of the Virginia Health Reform Advisory Council:

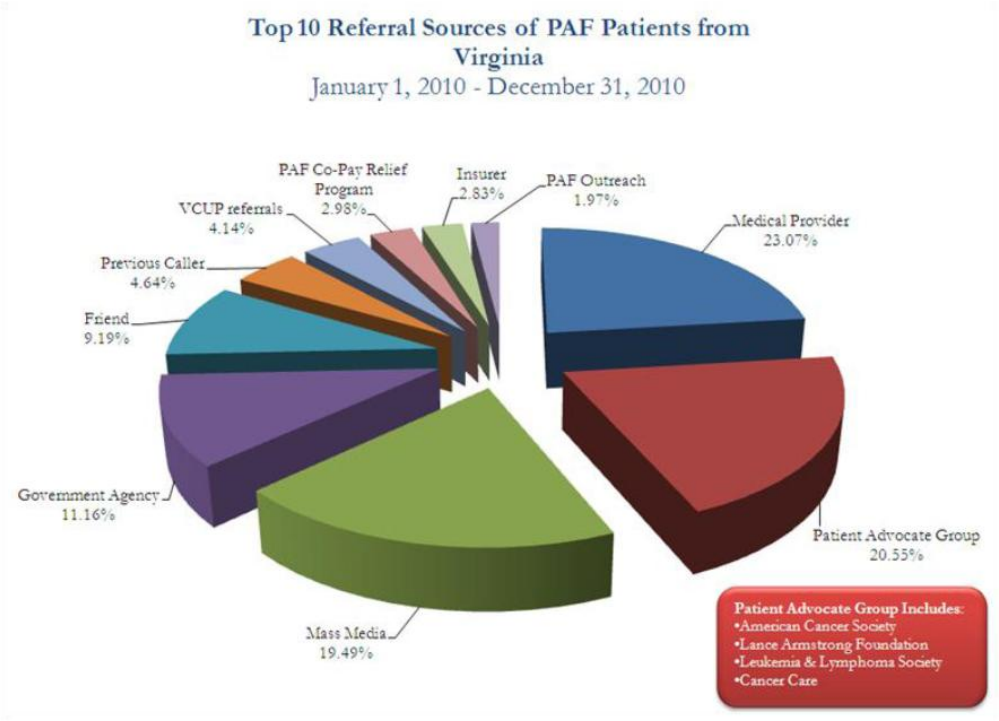
National Patient Advocate Foundation (NPAF) is the voice for millions of patients who have sought care after a diagnosis of a chronic, debilitating or life-threatening illness. Its advocacy activities are informed and influenced by the experience of patients who receive direct, sustained services from its companion organization, Patient Advocate Foundation (PAF), a business that employs 212 people in 9 states and whose national headquarters is in Hampton, Virginia. Founded in 1996, PAF is a national non-profit, 501(c)(3) direct patient services organization with a mission "to safeguard patients through effective mediation assuring access to care, maintenance of employment and preservation of their financial stability."

PAF provides professional case management assistance to patients with chronic, debilitating or life-threatening conditions. PAF serves as an active liaison between patients and their insurer, employer and/or creditors to resolve insurance, job retention, and/or debt crisis matters relative to their diagnosis through professional case managers and a national network of health care attorneys. PAF case managers work with patients and their providers to identify local, state, and federal programs that provide assistance for their individual needs, ensure appropriate reimbursement for healthcare services by their insurers and educate them on their employment rights during an illness. In 2010, PAF resolved 82,963 patient cases and received more than four million additional inquiries from patients nationally. PAF served 286,995 Virginians which accounted for 7.38% of the 82,963 cases.

NPAF appreciates the opportunity to provide comments on the third memo from the Virginia Health Reform Initiative (VRHI). NPAF leadership has participated in the public forums and has been impressed by the intellectual rigor that Virginia has allocated to providing options and recommendations on a Virginia Health Benefit Exchange (HBE) to the Secretary of Health and Human Resources. As noted in the memo, the intent of the HBE is

to improve small group and non-group insurance market performance through transparency, provide consumer education about various insurance choices, and provide assistance with eligibility determinations for Medicaid, premium assistance tax credits and cost-sharing reductions. The balance of this letter provides comments related to that intent informed by the collective experiences of Virginia patients who have contacted PAF for assistance in accessing quality care. Those experiences have been quantified in the PAF's Patient Data Analysis Report (PDAR) which illustrates the data collected across 260 variable by PAF senior case managers.

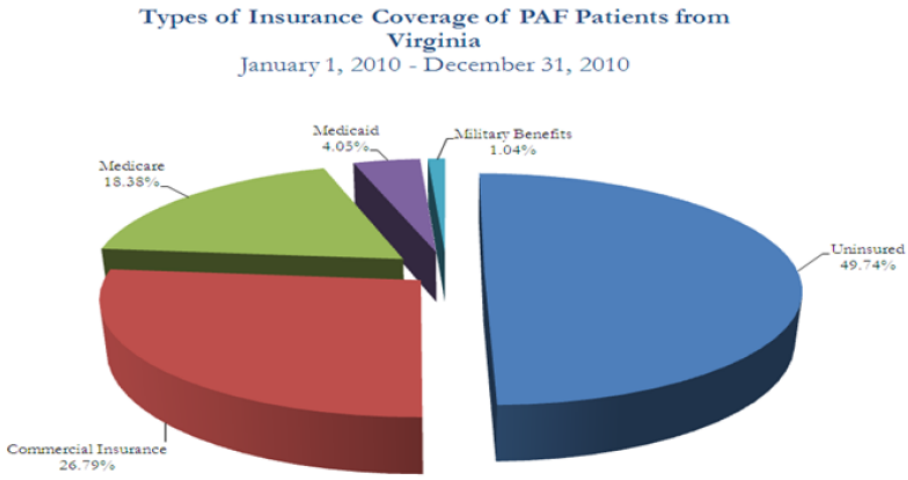
The number of Virginia patients contacting PAF is considerable, and the level of trust PAF enjoys from patient community and by other nonprofits is commendable. The 286,995 Virginia patients who contacted PAF last year came from a multitude of referral sources. Thus, NPAF's comments reflect patient experiences from a broad Virginia patient population base integral to its comments on Section VI's Basic Health Plan (BHP) considerations.



As the chart on the next page demonstrates, PAF has experience with all types of Virginia insurance providers and has considerable patient experience data which can inform VRHI's efforts to improve small group and non-group insurance market performance. It also provides information regarding the type of insurance products most likely to present challenges for patients suffering from chronic, debilitating or life-threatening illnesses.

As an outgrowth of the challenges PAF faces in mitigating patient access to healthcare problems across different insurance types, NPAF understands and appreciates the challenges VHRI faces in its BHP considerations. As noted in the memorandum, if the parameters of the BHP option are structured appropriately, it could have merits for the Commonwealth as a whole, specifically patients, and participating health plan. However, BHP creation means the expansion of another public health coverage option and it may also render the HBE vulnerable to adverse selection risks.

NPAF supports the creation of a BHP in Virginia for a number of reasons and believes there may be creative ways to mitigate or even present the challenges noted above. A comparison of the percentage of access problems experienced by patients with the Virginia Medicaid program reveals very favorable findings. While the percentage of PAF patients experiencing access problems with the Medicaid program is 9.19% nationally, only 4.05% percent of the Virginia patients experienced such access challenges. This result suggests Virginia's administration of public health programs is superior to that of other states when rating them by access to care challenges for medically vulnerable populations. It also buttresses the claim made in the memorandum regarding the relationship between Virginia's successful track record, and current planned expansion of Medicaid managed care and the clinical value and cost efficiency of continuous relationships with "usual source of care" providers with the likely success should the BHP option be appropriately structured.



The chart also illustrates the success of commercial health insurance plans serving patients in Virginia. While the national percentage of PAF patients experiencing access to care issues was 36.91%, only 26.79% of PAF patients from Virginia insured by commercial insurance experienced such issues. Thus, it is likely that the strength of the commercial carriers in Virginia will not be as susceptible to the adverse selection risks BHP introduction might pose in other states. While the percentage of uninsured is lower in Virginia than in other states, its percentage of uninsured population experiencing access to care challenges is greater. The national percentage in uninsured patients contacting PAF for access to care assistance is 27.71% while that same percentage in Virginia is 49.74%. It is likely the existence of a BHP and an HBE Virginia would address the greater access to challenges the uninsured populations faces.

Section V of the memorandum concerns the decisions that could be made by the Legislature, the Governance Structure, and the Director of the Health Benefit Exchange. NPAF concurs with the summary of decisions that could be made by each as defined and offers an addition to number 4 of the "Major Policy Decisions That Could Be Delegated to the Executive Director." NPAF concurs that the Executive Director should be allowed to enter into interagency agreements or memorandum of understanding with the Department of Medical Assistance Services, the Bureau of Insurance, and other appropriate

state agencies to coordinate, subcontract, share data, or delineate the roles of the agencies with the Exchange. NPAF suggests that the major policy decisions might also include the ability of the Executive Director to contract with members of the nonprofit community as appropriate. According to a study by the Johns Hopkins Center for Civil Society, Virginia's nonprofit sector is the second largest employer among Virginia industries. Many of them are within the health sector and are trusted by the patient community. Thus the nonprofit industry sector is uniquely situated to provide direction to the Executive Director.

NPAF concludes its comments to the Virginia Health Reform Initiative Advisory Council and Task Force Members by highlighting a white paper that it has drafted that has been reviewed favorably by health policy leaders in other states when considering exchange formation. The NPAF Essential Health Benefits white paper provides an important patient-centric perspective that must be considered if exchange formation is to be successful. Some of its comments may also be extrapolated to basic health plan development. A copy of the White Paper accompanies this letter.

Again, NPAF appreciates the opportunity to provide comments on the August 12 Memorandum on Preparing for Potential 2012 Health Benefits Exchange Legislation. PAF is pleased to serve as a resource in Virginia's exchange plan development.

Sincerely,

Nancy Davenport-Ennis
Chief Executive Officer

Rene Cabral-Daniels
Chief of Staff

National Patient Advocate Foundation

The Patient's Voice | since 1996

ISSUE BRIEF: Essential Health Benefits and Patient Centricity

July 2011

BACKGROUND

The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA),[1] creates exchanges, which are virtual marketplaces where individuals and businesses can compare health insurance product coverage as well as purchase health insurance.

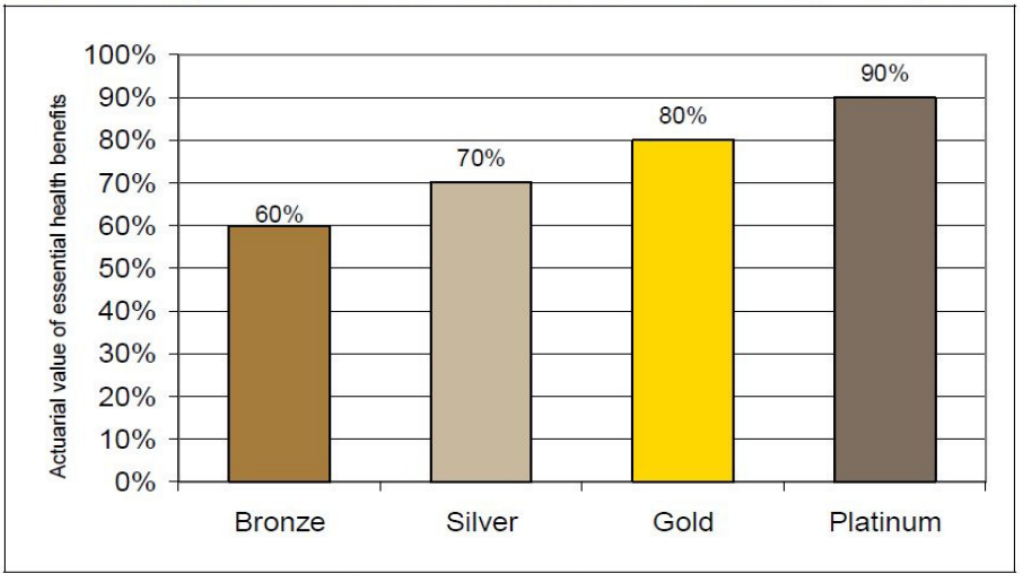
The products offered through exchanges are referred to as qualified health plans (QHPs), that may vary in coverage levels yet meet certain standards in categories of care and limits on patient cost sharing. The PPACA requires QHPs to cover the following general categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services including oral and vision care.

HHS is directed to specify the "essential health benefits" included in the "essential health benefits package" that QHPs will be required to cover (effective beginning in 2014) based on the scope of benefits offered by a typical employer plan. The agency must not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life, and must take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups. The PPACA also directs HHS to periodically review the essential health benefits and address any gaps in access to coverage.

HHS' success in appropriately defining essential health benefit packages will determine the success or failure of the program, and may serve as a litmus test for the overall value of health reform in general.

[1] Patient Protection and Affordable Care Act, §1302, p 45. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf. Accessed June 18, 2011.

Figure 1. Actuarial Values for Levels of Coverage Provided by Qualified Health Plans



Source: CRS analysis of the Patient Protection and Affordable Care Act.

THE FIRST STEP: THE DEFINITION

HHS' success in appropriately defining essential health benefit packages will determine the success or failure of the program, and may serve as a litmus test for the overall value of health reform efforts in general. HHS' website (www.healthcare.gov) promotes exchanges as private health insurance markets that will provide access to health insurance options to small businesses and to individuals. Exchanges are the vehicle by which health insurance consumers will be educated on how to choose a health insurance product and as well as the entity by which consumers will purchase these products. The ultimate goal is to have a greater number of Americans covered.

Health insurance products differ by coverage level. The PPACA stratifies levels of health insurance coverage that QHPs must provide into four color categories- bronze, silver, gold, or platinum. [2] Coverage levels will be based on a specified share of the full actuarial value of the essential health benefits (see Figure 1). Each specific service added to the essential health benefits package increases the total actuarial value of the plan as well as the actual dollar value of the enrollees' cost sharing. According to an analysis completed on behalf of the Kaiser Family Foundation by three actuarial and benefits consulting firms, a consumer purchasing a bronze-level plan could be responsible for a deductible ranging from $2,750 to $6,350 and a coinsurance rate for bills between the deductible amount and the out-of-pocket cost limit ranging from 0% to 30%.[3] The bronze level plan has the lowest actuarial value for level of coverage and therefore would cover only 60% of expenses before the out-of-pocket cost limit kicked in. (See Figure II from the Kaiser Family Foundation on next page.)

[2] §1302(d)

[3] Henry J. Kaiser Family Foundation, "*What the Actuarial Values in the Affordable Care Act Mean,*" April 2011.

Figure II. Estimates of Plan Designs Meeting Selected PPACA Actuarial Value Thresholds, 2014

			Actuarial Research Corporation		Aon Hewitt		Towers Watson	
	Actuarial Value	Out-of-Pocket Maximum	Deductible	Coinsurance	Deductible	Coinsurance	Deductible	Coinsurance
A	60%	$6,350	$6,350*	0%	$4,350	20%	$2,750	30%
B	70%	$6,350	$4,200	20%	$2,050	20%	$1,850	20%
C	70%	$4,200	$4,200*	0%	$2,650	20%	$1,550	30%
D	70%	$3,200	$3,200*	0%	$3,200*	0%	$2,050	30%
E	73%	$3,200	$3,200*	0%	$3,200	0%	$1,750	25%
G	87%	$2,100	$1,050	20%	$250	20%	$150	20%
I	94%	$2,100	$60	10%	$200	5%	$0	8%

Note: Amounts shown for the out-of-pocket maximum and deductibles are per person; figures for families would be double these amounts. Where an asterisk appears, the firm was unable to construct a plan design within the constraints of the actuarial value and out-of-pocket maximum. The deductible shown in these cases is equal to the out-of-pocket maximum, which is the highest it can be. The out-of-pocket maximum amounts are based on those for high-deductible plans that qualify to be paired with a Health Savings Account, inflated forward to 2014.

PATIENT DATA ANALYSIS REPORT

As documented in the preceding pages, it is imperative for HHS to carefully consider the pros and cons of each service inclusion to the essential health benefits package. The deliberative process must be a thoughtful one informed by a wide myriad of healthcare stakeholders. One important stakeholder is the patient advocacy community. These nonprofit groups serve as a trusted voice upon which health policymakers can rely to design programs that truly benefit patients. Their voice is also the voice that patients have relied on to receive information that they understand to be in their best interest.

The level of sophistication in advocating on behalf of patients that patient advocacy groups have attained renders their perspective pivotal if HHS is to realize the potential it claims PPACA offers. That potential can only be realized if PPACA programs are designed in a patient-centric manner. This means policies must be designed in a manner that considers their ultimate impact on access to quality health care services for patients. National data on patient access challenges is likely best exemplified by the Patient Advocate Foundation's Patient Data Analysis Report (PDAR). The Patient Advocate Foundation has a 15 year track record of serving as the trusted patient voice and compiles its efforts in resolving patient access issues into a PDAR. In 2010, PAF resolved 82,963 cases nationally and provided information to almost 4 million online contacts The PDAR reflects the extensive documentation recorded by PAF case managers as they resolve cases and input data on 260 unique data fields.

Information from the PDAR and any other similar quality documents should guide HHS's efforts when considering essential health benefit inclusion or exclusion. People with existing health conditions will be at the forefront of health consumers interested in health insurance coverage. HHS' efforts to define essential health benefits must not only consider the tension between health benefit inclusion and health insurance product cost, but what purchasing the insurance product will mean when the health consumer becomes a patient. The health benefit inclusion

deliberation must consider the health consumer as future patient.

One important, yet often under-appreciated challenge that faces people when they become patients is that of debt crisis/cost of living. The PDAR data reveal the uninsured population seeking its services had debt crisis/cost of living issues that increased to 19.77%, up from 10.27% in 2009, representing an increase of 92.50%. As noted in the PDAR, regardless of the presence or lack of health insurance, patients are struggling more and more with debt-crisis/cost of living issues that result from an onset of illness. These data reveal health insurance product costs will significantly impact health consumer decisions in general, and patient decisions in particular when purchasing health insurance products. While HHS is carefully considering health insurance product pricing in essential health benefit evaluations, it should also include patient debt crisis issues faced by patients who have coverage that is inadequate.

The adequacy of coverage will become increasingly more important as the American population ages and their illnesses become more serious. Patient severity of illness should be considered when estimating health costs of exchange consumers. The PDAR identified "no access to care" as the greatest sub-issue for the uninsured, representing 36.01% of uninsured issues. The second most frequently cited issue demonstrates the frequency of patient illness severity as a healthcare access issue. "No access/no coverage for prescription needs" grew to 19.76%, up from 15.48% in 2009.

Patient severity of illness will play an important role in defining essential health benefits not only because of the cost to adequately treat an aging population with severe illnesses yet not eligible for Medicare, but because of the nation's escalating incidence of disease chronicity and co-morbidities. Any health reform effort, including efforts to define essential health benefits must recognize that before we can bend the cost curve, we must first bend the chronicity of disease curve. The Robert Wood Johnson Foundation predicts that by 2020, 164 million people (almost 50% of the population) will have a chronic condition and 81 million (24%) of them will have two or more conditions.[4]

An essential health benefit definition must address the adequacy of health insurance coverage, particularly for a nation experiencing an exponential growth in chronic disease prevalence. Health policymakers should be guided by an Institute of Medicine quote on patient care- "Getting the right care at the right time to the right patient for the right price." Escalating chronic disease incidence must be factored into any essential health benefit definition otherwise this trend will frustrate attempts to realize true health care savings. The costs savings that might be achieved by health consumer purchases of attractively-priced yet benefit-poor health insurance products might

Any health reform effort, including efforts to define essential health benefits must recognize that before we can bend the cost curve, we must first bend the chronicity of disease curve.

[4] Wu S, Green A. Projection of chronic illness prevalence and cost inflation. Prepared for Partnership for Solutions by RAND Corporation. Baltimore: The Johns Hopkins University; 2000.

be consumed by the cost of a shrinking healthy workforce resulting from people unable to receive the care necessary to remain in the workforce.

The PDAR data make a strong case for the assertion that essential health benefits must include any and all health benefits that help patients suffering from chronic, debilitating and life-threatening diseases. Although the inclusion of such comprehensive benefits will certainly raise the price of insurance products, government must weigh the price of subsidizing those costs with the cost of having a growing population burdened by chronic disease who without adequate access to healthcare will simply become unable to contribute to growing the economy as their disease state worsens and becomes financially more difficult to address.

The PDAR data on commercially insured patients reveals issues involving debt crisis/cost-of-living, medical co-payment, and pharmaceutical co-payment represented 61.17% of all issues reported by commercially insured patients, which increased from 56.06% in 2009. These data evidence the fact that mere health insurance coverage does not prevent access to care challenges. Health benefits must be robust enough to make health insurance coverage the gateway to healthcare access.

The PDAR data make a strong case for the assertion that essential health benefits must include any and all health benefits that help patients suffering from chronic, debilitating and life-threatening diseases.

RECOMMENDATIONS

Based upon the PDAR, NPAF makes the following recommendations:

A. The definition of essential health benefits must not be merely appealing to health consumers, but must include benefits that consumers will be able to avail themselves of when they become patients. Health benefits become essential health benefits when the consumer steps into the role of patient.

NPAF believes any state health exchange implementation process shouldn't frustrate the ability for patients to avail themselves of the most essential of benefits, provider choice and specialty care.

B. HHS must consider the fact that provider choice may be implicitly impacted by essential health benefit definitions as practice patterns vary. For example, to accommodate practice patterns, any essential benefits package must include oral chemotherapy parity through major medical coverage, and define "experimental" to include patient benefit for the purposes of determining acceptable treatments.

C. To be truly considered patient-centric, essential health benefit definition must consider the economic and social issues that patients endure. Hidden costs not only affect patient ability to afford medical treatment, but can have devastating effects on their economic status and the economic future of our country.

Essential health benefit identification is only the first step in assuring health consumers, particularly patients get the care they need. Exchanges must be operated in a manner that educates consumers of this important benefit.

D. Regarding the operations of exchanges -

i) HHS should assign appropriately trained officials to provide consumers with information about specific insurance-related questions regarding the exchange.

ii) HHS should utilize a standard format when presenting plan options and costs, thus allowing consumers to efficiently compare options and choose their plans accordingly. Any printed or online material should be written at a 6th grade reading level in order to communicate information that consumers can fully understand in culturally sensitive language.

HHS should utilize a standard format when presenting plan options and costs, thus allowing consumers to efficiently compare options and choose their plans accordingly.

iii) HHS should provide a toll-free information hotline operating on Saturday and after business hours, as well as an automated frequently asked questions and answers option for those consumers who may not be able to call during normal Monday-Friday business hours. The exchange should make online support available that includes responses to online inquiries.

iv) HHS needs to make sure that whatever exchange design is selected, legislative language is clear enough not to cause any ambiguity.

v) The exchange governance process needs to be transparent, and provide adequate opportunities for patient advocates to be involved in the implementation process. Patient advocates should include those who have years of advocacy experience and a good reputation in the patient community.

E. Regarding the enrollment and eligibility of consumers accessing exchanges -

i) HHS should provide two options for consumers to enroll in the exchange, via phone and online. NPAF recommends that the preferred enrollment method should be online, as online enrollment can benefit both consumers and insurers.

ii) Real-time personal assistance must be made available during hours which potential enrollees are most likely to view the site, such as 8:00 AM to 8:00 PM.

iii) HHS should develop a brief, easy-to-understand paper handbook that describes the essential health benefits as well as the online enrollment procedure in a step-by-step format. Enrollees may find this a useful tool when attempting to enroll online.

iv) In the event that consumers may not be able to utilize the online application tool, NPAF recommends establishing service centers with staff who can walk applicants through the process. NPAF also recommends contracting through a public/private partnership with existing non-profit patient service groups to assist with this initiative.

F. Regarding outreach for consumer enrollment -

i) Because the exchange program with its array of products will be difficult to explain to consumers who haven't previously had to make selection decisions relative to insurance, the methods that are used to convey the information must be simple and easy to use. In

this capacity, HHS should conduct town hall meetings in public venues such as libraries, community centers and free clinics, and distribute impartial information about essential health benefits and plan choices through national non-profit patient organizations. An enrollee survey system to evaluate consumer satisfaction with participating plans should also be developed.

ii) HHS may want to consider the important role that social media plays in informing "young invincibles" when designing outreach material.

G. Regarding consumer experience and their perception of ease-of-use -

i) NPAF believes that a clear, detailed explanation of each plan and any optional services should be provided. In order to disseminate plan information and assist in best choice selection by consumers, web presentations in a variety of languages and partnering with large retailers and employers, including the U.S. Chamber of Commerce and the National Federation of Independent Business, should be considered.

ii) NPAF also recommends reaching out to culturally appropriate organizations, inclusive of churches, sororities, fraternities, community health centers, free clinics and Indian Health Services, as they are trusted sources within certain cultural communities.

Conclusion

While the federal government has yet to define the essential benefits required for plans operating in the exchanges, its consideration should not be limited to pricing health insurance products so that they are attractive to consumers but rather assuring health plan benefit adequacy so that they improve the health of consumers when they become patients, which will benefit the health of our economy.